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**Mental Health and Learning Disability Nurse Prescribing as an  
Example of New Ways of Working: An Evaluation of Practice to Date**

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# **Mental Health and Learning Disability Nurse Prescribing as an Example of New Ways of Working: An Evaluation of Practice to Date**

Eleanor Bradley

## **Abstract**

The New Ways of Working Programme (NWW) supports the ongoing modernisation of the NHS by encouraging existing staff to evaluate their roles and responsibilities with a view to the full utilisation of skills across the workforce. Non-medical prescribing provides an example of workforce change and role development by which NWW can be critiqued.

The introduction of non-medical prescribing within mental healthcare has supported the development of new services, increased access to medicines, promoted a holistic model of care, and reduced the distance between medical and non-medical colleagues. Nurse prescribers with access to organisational and team support have proved to be safe and confident prescribers. However, a large number of nurse prescribers working in mental health services have failed to utilise their roles in practice, highlighting concerns about how to inform team members, service users and carers, about new roles, how to utilise new roles without destabilising the team as a whole, and how to employ innovative measures to evaluate the impact of new roles in practice.

This article highlights and discusses these issues, and considers the current evidence surrounding the role of the nurse prescriber in mental health and learning disability care settings. The article also explores the role of healthcare professionals in supporting service users and carers to navigate through a modernised NHS.

**Key words:** Nurse Prescribing, New Ways of Working, Role Development, Modernisation, Supplementary Prescribing

## **Introduction**

In order to meet increasing demands for health care, professionals are being encouraged to work in ways that increase efficiency and effectiveness (Murphy 2007). The New Ways of Working (NWW) programme (Department of Health 2006a) is a collaborative venture to support the ongoing modernisation of the NHS through a cultural shift in service provision, promotion of distributed responsibilities and full utilisation of existing skills within the current workforce. The NWW programme proposes to give direction to healthcare professionals to deliver effective, person-centred services alongside these changes to current workforce practices. Qualified staff are encouraged to extend the boundaries of their current practice and new roles, including primary care mental health workers and assistant practitioners, have been outlined.

There are currently a number of pressing issues for those working within mental healthcare including workforce shortages, an ageing workforce, the desire to offer service users more choice, and the treatment of service users with co-existing long-term physical health difficulties. With respect to NWW, traditional roles including those of psychiatrists, psychologists, OTs and nurses are being evaluated, and there are a range of opportunities for staff members to look at the remit of their roles and explore the possibility of extending the boundaries of what they do. For mental health nurses, these opportunities include nurse prescribing and adoption of the Responsible or Approved Clinician role. With the move towards integrated health and social care, those delivering services are charged with

considering inter-agency working in order to promote a whole systems approach to care. This reflects a common theme within NWW, that of services taking a holistic approach to care, and an increased appreciation of the social causes that underpin many mental health problems, including poverty, stigma, lack of early intervention and disempowerment (Department of Health 2006a).

Nurse prescribing (NP) has served to support the modernisation of healthcare services (Rodden 2001), but also provides an example of workforce change and role development by which NWW can be critiqued. In mental health care, doctors have historically been the only healthcare professionals permitted to prescribe medication for service users. The extension of prescribing rights to appropriately qualified nurse prescribers was initially proposed in the UK in the 1980s and nurse prescribing became a national initiative in 1998 (Luker & McHugh, 2002). In 2001, prescribing was extended and appropriately qualified mental health nurses were able to prescribe all general sales list pharmacy medicines and a further 200 prescription only medicines (Department of Health 2002). However, the limitations of the extended nurse prescribing formulary prevented many mental health nurses from actively prescribing and many did not opt to train as prescribers until the introduction of supplementary prescribing in 2003. As a supplementary prescriber, nurses are permitted to prescribe any drug from the British National Formulary (BNF), provided they are working from a clinical management plan that has been put in place for that specific service user and been fully agreed with a medical practitioner and the service user (Department of Health 2003). In 2006, appropriately qualified nurses (including those working in mental health) and pharmacists were permitted to prescribe independently, granting them authority to prescribe any licensed medicine within their scope of practice (Department of Health 2006b).

The introduction of nurse prescribing stimulated a good deal of debate from a wide range of healthcare professionals, including doctors and nurses. Some of this was critical of the initiative, and concerns were raised about whether nurses were taking on medical responsibilities without sufficient training or experience (Bullock & Manias 2002; Wilhelmsson & Foldevi 2003; Skingsley et al 2006). The introduction of prescribing within mental health has also attracted debate and questions have been raised about the appropriate environment for mental health nurse prescribing, the training currently offered and the support needs of nurses post-qualification. There has also been discussion about how prescribing could alter the role of the mental health nurses, with concerns raised about the potential for nurse prescribing to blur roles within multi-disciplinary teams (Nolan & Bradley, 2007; Basford & Bowskill 2001). It has also been suggested that encouraging mental health nurses to undertake prescribing could shift them from a model predominantly focused on 'caring' to a medical model approach of 'curing' (Baumann et al 1998).

The selection of appropriate nurses to undertake prescribing training is key to the subsequent success of the prescribing initiative. When supplementary prescribing was first introduced, a study conducted to look at the profile of early trainees found that employers selected the most highly educated and experienced nurses working across mental health and learning disability services to undertake training (Bradley et al 2005). However, as nurse prescribing has rolled-out across organisations, selection has not followed a strategic pattern (Dobel-Ober, Brimblecombe and Bradley, in press). One of the consequences of this has been that many nurses who qualified as supplementary prescribers have failed to utilise their roles in practice (Bradley, Nolan and Wain 2008). Barriers to implementation have included: organisational factors, particularly a lack of systems and governance procedures in place to support prescribing, selection factors, including the inadequacy of non-medical prescribing to address the needs of the service and qualified nurses feeling unprepared for prescribing practice; and finally, support factors, with nurses being unable to access support in practice from medical colleagues, team members and other qualified nurse prescribers (Bradley and Nolan 2007). The absence of work planning to ascertain how many nurse prescribers are required within multidisciplinary teams (MDTs) has resulted in some nurses working in

isolation from other non-medical prescribers and these nurses have experienced difficulty accessing appropriate support to implement their roles and maintain their confidence (Bradley et al 2007). Some nurses described working within teams where members misunderstood their new prescribing role. In particular some team members appeared to believe that, post-qualification, nurse prescribers would become the 'prescribing nurse' for the team, writing prescriptions for service users seen across the team, rather than those with whom nurses have completed individualised CMPs. The complex nature of the supplementary prescribing role has also proved difficult for service users and carers to understand (Bradley & Nolan 2007), particularly as mental health nurses are responsible for outlining the remit of their practice on an individual basis depending on their perceived competency.

## **Early Indications**

Despite some initial barriers to the implementation of nurse prescribing, particularly in mental health and learning disability settings, evidence suggests that nurse prescribing has brought about a number of benefits including faster access to medicines, reduced waiting times, greater involvement in treatment decision making and better use of the existing skills in the workforce (Latter et al 2004; Day 2005; Jones 2007; Norman et al 2007). Nurses are thought to be more likely to work from a holistic model of care, considering non-medical alongside medical approaches to care (Stenner & Courtenay 2008; Russell et al 2003; Bradley & Nolan 2007). Service users have been largely satisfied with the care received from nurse prescribers and have elicited a number of key benefits to nurse prescribing. In particular, service users feel that nurses have more time to spend with them discussing their medicines than doctors, and that they can ask them more questions about their medicines (Skingsley et al 2006). However, much of the research conducted to examine the impact of nurse prescribing in practice has been descriptive in nature, and has relied on self-report from nurses, prescribing colleagues and service users. There has been little work conducted to elicit either the clinical outcomes of nurse prescribing, or the impact that nurses could have on concordance or adherence rates within mental health. Furthermore, there has been little exploration of whether nurse prescribers conducting medication reviews with service users are more likely to involve them in decision-making than doctors, or whether service users are more satisfied with their medication reviews when they are conducted by nurses (and whether either of these factors could impact on concordance or self-management in a community setting).

Early concerns about nurse prescribing focused particularly on safety and whether nurses has sufficient training in assessment techniques, or received enough information about pharmacology in order to prescribe (Latter et al 2004; Barber et al 2003; Mayo & Duncan 2004; Day 2005). Despite some of these early fears, nurses who have received adequate support within their workplaces have proved to be safe and cautious prescribers, keen to keep their prescribing practice within their competency (Armutlu et al, 2008; Brooks et al, 2001; Avery et al 2004; Bradley, Nolan and Hynam 2007; Latter et al 2007; Jones et al 2007). Indeed, Goswell et al (2009) suggest that the introduction of non-medical prescribing to acute physical care environments has encouraged safe prescribing and collaborative working across MDTs.

## **Implications of Innovation to Date**

Although it is reassuring to see that nurses are capable of safe prescribing, some nurses have proved to be so cautious about their prescribing practice that they have opted never to prescribe (Bradley et al 2008). Some nurse prescribers from mental health and learning disability backgrounds have described feeling unprepared for prescribing by the generic training courses currently offered by universities, with further education and support

requested particularly in the area of neuropharmacology (Skingsley et al 2006). Post-qualification, organisations are responsible for supporting nurses with their prescribing practice, and this leads to a lack of parity in the education and support received by nurse prescribers once they return to practice. Some organisations have offered nurse prescribers extra training in the area of neuropharmacology which, although well received (Skingsley et al 2006), have not yet been evaluated with respect to their impact on practice. Many nurses who have opted to undertake the prescribing role describe having previously prescribed 'by proxy' where they have suggested prescriptions to medical prescribers for service users in their care. As such, the nurses felt they were already acting as medicines experts and that the prescribing qualification would underpin this role (Bradley et al, 2005). However, post-qualification, some nurses felt that the training course had highlighted the dangerous nature of this 'by proxy' role, and increased their awareness of the complexity of prescribing decision-making. Furthermore, some nurses felt the prescribing training merely outlined areas where they lacked knowledge and they became aware of 'not knowing what they didn't know' (Bradley, Nolan & Hynam 2007). This undermined their confidence as a medicines expert and discouraged them from prescribing in practice (Bradley, Nolan and Wain, 2008). One of the ways that nurses managed to dismantle this barrier was via support from medical mentors in practice who proved to be a resource for further learning and the development of confidence and competence in prescribing practice. Although one of the proposed benefits to nurse prescribing was the development of autonomous working for nurses, this highlights the importance of prescribing being a team activity, with supportive contact between prescribers in practice essential for retaining safety and developing competent prescribers. Indeed, one of the difficulties presented by limiting the numbers of prescribers within teams to medical team members only could be the reduced number of colleagues available for discussion of difficult prescribing decisions. In this respect, nurse prescribing could be described as opening up prescribing across the MDT, allowing doctors and other prescribers to consider their prescribing decisions from alternative points of view, and providing another reassurance of safety. Involving service users in this discussion and debate has the potential to enhance satisfaction and concordance with mental health prescribing, and could promote adherence. However, service users and carers require timely, accessible and good quality information to support their involvement in this process. Further work to examine the type of information that could support involvement is required, as well as investigation into the support required by professionals to enhance their provision of this information.

## **Policy Directives vs Organisational Culture**

The difficulties imposed by supplementary prescribing on the development of an accurate, shared understanding of the prescribing role in practice have already been illustrated. The successful implementation of new roles in practice is reliant on good communication across teams, ideally prior to team members being selected for training. Those adopting new roles are required to return to their MDTs, which remain unchanged. As such, all team members must consider how new roles are going to 'fit' within existing teams, and what the impact could be on all those working within the teams. It is important that this process does not serve to fragment service user care, or undermine team members. Furthermore, care should be taken to ensure that services do not end up with a lack of parity in the type of care that can be offered to service users. If there is only one qualified nurse prescriber working within an MDT, only a small proportion of the service users seen by this team will access care of this type. As well as causing a lack of parity, the consequences of this could be increased levels of dissatisfaction from service users/carers.

Future challenges for mental health and learning disability nurse prescribers include the reconciliation of prescribed medication with other interventions. Prescribing is one of a number of tools to be utilised by mental health nurses to promote recovery, but is only part of a much larger therapeutic toolkit (Hemingway and Ely 2009). Mental health service users are

at the forefront of the Choice Agenda with respect to decisions about medical and non-medical interventions, particularly with the introduction of the Increasing Access to Psychological Therapies (IAPT) programme. However, it is not clear what kind of information and support service users require in order to make informed decisions and choices about the care they want to help them cope most effectively with their mental health difficulties. As well as the care provided by the NHS, service users access a range of other sources of care and support via the voluntary/third sector, and the internet. NHS healthcare professionals, in focussing on the care provided by this one sector, may miss other sources of support being accessed by service users and carers. As well as needing more information about how service users and carers navigate the wide range of available interventions designed to alleviate their mental health difficulties, more guidance is needed as to who the best people are to support service users through this maze of information. Those prescribing medication to service users may not be the best sources of objective support to service users making decisions about whether medication is their preferred treatment option. Although nurses have been found to have benefited service users (Jones and Jones 2006), it remains to be seen whether nurse prescribing streamlines or fragments patients' experiences (Bramley 2006). It may be that there is a need for nurse prescribers to consider acting further in an advocacy role during medication reviews, to support service users to make informed decisions about their treatment choices, particularly at times of medication review.

Communication skills are paramount in the individualisation of resources for service users. However, it is vital that the care/treatment offered to service users can be delivered by teams. To support this, MDTs need to consist of team members with a wide range of skills, ability and knowledge (in order to signpost to services that cannot be offered within the team). There is a need for training, education and support to be structured around the effective development and provision of packages of care to service users, rather than purely on the basis of individual development. A full evaluation of the impact of NWW on MDTs should be conducted within organisations in order to establish where key areas of needs are falling. Collaboration with Universities is important to ensure that the training and education being offered is suitable to meet the needs arising from MDTs, and all training/education should be evaluated for impact on the team. Furthermore, training and education should be delivered within groups that best represent MDTs, rather than uni-disciplinary groups as per tradition. It is interesting to note that one of the early concerns elicited from non-medical prescribing trainees in their first week of training was the mixed nature of the training groups with respect to nursing specialities. However, despite these early concerns, the variety of backgrounds and interests in mixed training groups proved very helpful to trainees who were able to consider different ways of utilising prescribing in practice, alongside suggestions to dismantle barriers (Bradley et al 2006).

## **What is Evident to Date**

Nurse prescribers have been able to utilise their roles in order to develop new services, reduce pressure on existing services, increase access to medicines for service users, streamline care, reduce domination of the medical model within mental healthcare, and promote a holistic approach to care (Latter et al 2004; Bradley and Nolan, 2007; Norman et al 2007). The introduction of nurse prescribing has also promoted better collaboration between medical and non-medical colleagues, and the role of the nurse prescriber as a medicines expert has been legitimised within the MDT (Bradley and Nolan 2007). The benefits outlined above have been realised even when nurse prescribers have failed to utilise their roles as originally intended i.e. by writing out scripts (Bradley et al 2008). Mental health nurses working across community settings have been particularly successful in utilising their prescribing qualification to further their understanding of how service users and carers self-manage their medication, and to encourage effective self-management and the reduction of symptoms and side effects. However, formal recognition of the importance of utilising nurse prescribing in this way has not yet been possible as informal feedback from

nurse prescribers suggest that Trusts may rely predominantly on audits of prescribing activity to consider the number of scripts produced by nurses, and little other information. Having gained authority to prescribe, some nurses are choosing not to write prescriptions as a first-line treatment, but to work with service users to ascertain more fully their treatment needs, in particular whether prescribed medication is their preferred option for care. This holistic approach to care, outlined by nurses as a key reason for engaging with the prescribing initiative, recommends the utilisation of the non-medical prescribing role in this way. As such, the successful roll-out of nurse prescribing within organisations may actually result in reduced numbers of prescriptions, but enhanced concordance and service user satisfaction with care.

## **Future Challenges and Opportunities**

There are a number of future challenges for mental health and learning disability nurse prescribing. As described, collaborative working is a vital element of non-medical prescribing and is necessary in various forms including:-

- Between doctors and nurse prescribers
- Between pharmacy and nurse prescribers
- Between nurse prescribers
- Between nurse prescribers and other non-medical prescribers
- Within multi-disciplinary teams
- Between healthcare organisation management teams and multidisciplinary team members
- Between primary and secondary care
- Between healthcare organisations and higher education institutions

The non-medical prescribing initiative has highlighted a number of issues and concerns that can be generalised to the roll-out of other new roles as part of NWoW. For the nursing profession, the nursing role looks likely to be extended yet further and nurses need to consider where 'nursing' fits within these extended roles, how to reconcile new medical responsibilities alongside other non-medical interventions and approaches to care including IAPT, input from the voluntary sector, and public access to the internet. As the Choice Agenda moves apace, and service users become able to access care and a range of treatments from a range of different professionals, further consideration of how to enable effective choices, and the effective communication needed to share information about these choices with service users, is paramount. All training courses initiated to extend the working roles of healthcare professionals should incorporate effective communication training in order to support professionals to consider how best to communicate their new roles to team members, service users and carers. Workforce planning is required to underpin the need for new roles, and to support the effective implementation of these roles. Following implementation all new roles should be evaluated in practice to demonstrate impact as well as support or training needs (for staff and service users/carers).



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